

# Exhibit K

**CONFIDENTIAL**

Stephen K. Martin, Ph.D.  
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**Neuropsychological Consultation Note**


Patient Name: Brice McBay Social Security #: 458.95.4195  
Date of Evaluation: 6/5/09  
Referral Source: Mike Bruffey, Attorney At Law  
Brown Buchanan, PA  
Consulting Neuropsychologist: Stephen K. Martin, Ph.D.

Brice McBay attended a one hour appointment today in order to update his current status. Brice continues to assist his father as an insurance adjuster. He reports continued difficulty "keeping up" with all the daily changes that accompany a job of this type. He specifically feels that his attention and multi-tasking capacity remain problematic although he is compensating by double checking his work, writing things down, etc.

Brice acknowledges that a potentially greater limiting work factor than cognitive issues remain his reduced capacity to handle stress and to deal with the inter-personal components that are required to work as an adjuster. I would agree that these "interpersonal" issues appear to be affecting him to a greater degree than cognitive issues. For instance, he indicated that whereas he was able to previously negotiate with contractors, adjusters, etc as part of the job, it all "irritates" him now and therefore his father does these aspects. He continues to report quick anger and irritability as well as social withdrawal tendencies. He indicated that he no longer calls his friends or wants to go to public places. In general, he recognizes that he is less "emotionally attached" to people now and simply doesn't enjoy life to the same degree.

Emotionally, Brice described himself as being "down", but did not relate to being depressed per se. He indicated that he continues to be "stressed and tired". Upon presentation, his mood appeared somewhat dysphoric and his affect was restricted. He continues to experience vegetative symptoms including disruptions involving sleep, appetite, energy, and interests. He reports that the frequency of his nightmares has improved but now he just has weird, disturbing dreams. He is denying any suicidal ideation at this time, and drinks alcohol in a limited fashion. Brice indicated that he knows he needs more help to continue to overcome the effects of this incident in his life, and would like to re-initiate therapy.

Based upon this consultation, I will be requesting follow-up counseling at a frequency of every 6 - 8 weeks given Brice's work situation. He is not comfortable with medication management and therefore no recommendations are being made in this regard. Other treatment recommendations remain the same as stated in my letter dated May 29, 2009. Thank you.

  
Stephen K. Martin, Ph.D.  
Clinical Neuropsychologist

OCT. 1. 2008 9:47AM

STEPHEN K MARTIN PHD

NO. 942 P. 2

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### Neuropsychology Update Report

Patient Name: Brice McBay

Social Security #: 458 95 4195

Date of Report: 11/1/08

Requesting Source: John Foxworth, Jr., Attorney At Law

Consulting Neuropsychologist: Stephen K. Martin, Ph.D.

This report was prepared at the request of John Foxworth, an attorney representing Mr. McBay. In his letter dated September 30, 2008, he requested that I provide relevant information in order to address the following issues:

1. **Diagnosis of Injuries:** As stated in the neuropsychological evaluation dated 12/3/07, the following diagnoses were made:

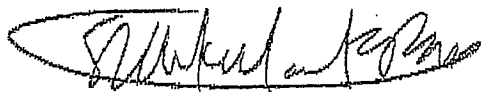
850.0	Concussion
310.1	Organic personality syndrome
310.2	Post concussion syndrome (PCS)
309.81	Post traumatic stress disorder (PTSD), chronic
296.22	Major depression, single episode, moderate

2. **Causal relation of injuries to the jail beatings:** As stated in the neuropsychological evaluation on 12/3/07:

From a diagnostic standpoint, these results reflect indications of frontal lobe dysfunction consistent with residual effects from a concussion sustained in the reported assault. Primary brain regions affected by this concussion involve frontal and more specifically orbital-frontal regions of the brain. Primary cognitive areas which continue to be affected include elements of attention, processing speed, decision-making, as well as visual memory and recall. Of equal if not greater concern with these cognitive deficits involves the aforementioned mood and personality changes. These behavioral symptoms frequently accompany injuries involving orbital-frontal regions of the brain. The combination of cognitive, emotional / behavioral, and physical symptoms (e.g., headaches, lethargy) being reported are referred to as a post concussion syndrome (PCS). These concussion factors tend to dynamically interact with one another in such a way that improvements in one area (e.g., mood) may result in associated improvements in another area (e.g., cognition). The time frame that has elapsed since the injury (approximately 2 years) suggests that elements of this profile are likely permanent in nature.

3. **The effect on ability to work and function:** At this time, Mr. McBay continues to work in a reduced capacity with his father who is an insurance adjuster. In essence, Mr. McBay is working as an assistant to his father whereas prior to this incident he was working independently as an insurance adjuster. His ability to work in an independent fashion continues to be affected in a negative manner by the cognitive and emotional / behavioral effects from this injury.

4. **Prognosis:** Mr. McBay's prognosis remains guarded due to the continued long-term residual effects stemming from the post concussion syndrome and PTSD. We have recently initiated follow-up counseling, and Mr. McBay appears quite motivated and is responding in a positive fashion to the treatment. His prognosis may improve with continued neuropsychological counseling, as well as with participation and follow through in the other recommendations specified in the neuropsychological evaluation dated 12/3/07.



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 Clinical Neuropsychologist

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Neuropsychology & Behavioral Medicine

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May 28, 2009

Brown, Buchanan, PA  
796 Vieux Marche, Suite 1  
Biloxi, MS 39530  
ATTN: Mike Bruffey

RE: Brice McBay

Dear Mr. Bruffey:

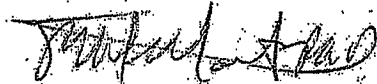
Attached please find my initial neuropsychological report on Brice McBay dated 2/3/07.

Causation: Based upon data from that evaluation as well as clinical information obtained over the course of our treatment, it is my opinion that the alleged assault on 11/6/05 is responsible for the concussion, post-concussion symptoms, and post-traumatic stress disorder (PTSD) that Brice continues to experience.

Future Treatment: Consistent with information given in the initial neuropsychological evaluation, I believe that the following treatment is necessary to enhance Mr. McBay's recovery efforts:

1. An outpatient cognitive rehabilitation program with a primary focus on neurocognitive recovery. My office does not provide this treatment, and the closest program of this type is located in the Dallas, TX area. The cost of a program of this type would vary depending upon its frequency, intensity, and longevity. One program of this type in Dallas, TX involves the office of Richard Fulbright, Ph.D. and Associates. They charge \$150.00 per hour for neurocognitive rehabilitation, typically at a frequency of 2 hours per day, 3 days per week. For a three month program, this would cost approximately \$11,000.00; a six month program approximately \$22,000.00. The length of treatment would vary depending upon his clinical response and level of improvement.
2. Follow-up neuropsychological counseling would help provide needed support and education to Mr. McBay. These sessions would ideally occur following the completion of the cognitive rehabilitation program and would focus on problem-solving everyday issues that accompany long-term post-concussion issues, utilizing compensatory strategies, as well as mood stabilization in response to his PTSD issues. My office does provide this type of treatment. The cost of this treatment is \$175.00 per session, and 30 sessions spread over a three year period would cost \$5250.00.

I will be seeing Mr. McBay again on June 5, 2009 and will provide a supplemental report following this session. As always, I reserve the right to modify these recommendations based upon additional information.



Stephen K Martin PhD  
Clinical Neuropsychologist

EXHIBIT "D"

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### Neuropsychological Evaluation

Patient Name: Brice McBay Social Security #: 458 95 4195  
Date(s) of Evaluation: 12/3/07 Age: 31 Education: 13  
Handedness: Right Referral Source: Jim Halliday, Attorney  
John Foxworth, Jr., Attorney  
Consulting Neuropsychologist: Stephen K. Martin, Ph.D.

**Reason For Referral:** Brice McBay was referred in order to clarify his current cognitive and emotional status.

**Relevant History:** Information obtained in this section was derived from clinical interview with the patient, as well as interview with his parents, sister, and girlfriend. The patient reported that on 11/6/05 he was arrested and jailed in Gulfport, Mississippi. Mr. McBay reported that he was 'hog-tied' and thrown in the back of police car for transport to the jail. Once he arrived at the jail the patient reports that he was intimidated, harassed and beaten. He reported general recall of the incidents that led up to his arrest which included having drinks at a local bar, as well as general recall of the alleged assault. Mr. McBay reported that he was incarcerated from approximately 7:30 pm on 11/6/05 until the early afternoon of 1/7/06. His father picked him up and noted that the patient had swelling on the left side of his face, a blood shot left eye, as well as a broken nose. He also reportedly had diamond shaped scuff marks on his face. Mr. McBay reportedly had a "blank" and "dazed" look on his face. His father took Brice directly to the emergency room where he was evaluated and released, and these ER records are reviewed below. To date, Mr. Brice reported that he has been treated by a Neurologist, ENT physician, Eye Doctor, as well as his family physician.

Initial cognitive symptoms included a dazed feeling and inability to work or dress himself without help. The patient also reported limited recall for the initial ten to fourteen days following the incident. Current cognitive symptoms include short term memory problems including reduced recall of conversations and difficulty recalling job tasks. Mr. McBay also reported that he struggles with word finding, concentration, processing speed issues, as well as multitasking problems. He also stated that his sense of direction is not as strong. He is independent for all activities of daily living. The patient reported that he previously took an online IQ test and "qualified for MENSA" by scoring in the 130's. He was pre-morbidly described as being very fast and was an "over achiever" from a work standpoint.

In general, the patient feels inadequate when compared to his prior cognitive skills. Initial physical symptoms include head aches, blurred vision and tinnitus. Current physical symptoms include chronic low grade fever, lethargy, decreased energy, as well as bilateral hand numbness, left worse than right.

With regard to his behavioral status, the patient reported that he is more irritable and easily frustrated. Mr. McBay acknowledged that following the incident he stayed drunk for a "long time" to avoid thinking about what had happened to him. He acknowledged attempting to push back thoughts of the assault for quite some time, but the thoughts have recently continued to surface in spite of these attempts. He is reporting increased nightmares including vivid, violent dreams, as well as increased anxiety symptoms when he sees or interacts with policemen. He is particularly untrusting of authority figures. His family reported that Brice has become more paranoid and is



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much less trusting of other people. In addition, they reported that the patient is more reactive with anger and now tends to give up easily.

The patient's medical history is positive for hypoglycemia and hernia. There is no history of concussion or brain injury. He smokes cigarettes daily and reportedly increased his alcohol intake following the incident; however, he has since reduced his alcohol intake. The patient is a graduate from DeSoto High School in DeSoto, TX, and indicated that he was diagnosed with dyslexia and ADHD in the 1<sup>st</sup> grade. However, there was a desire to avoid medication management for these symptoms. Instead, Brice reported that he has always approached school as though he had to prove himself to others as well as prove himself academically. Prior to this incident, Bruce was described as an over-achiever in most aspects of his life.

Brice works as an insurance adjuster and was working in this capacity at the time of the incident. Mr. McBay reported that he was very good at his job prior to this incident. Mr. McBay's family initially helped to cover for him at work including his father checking his work. He has not worked full time since the incident, although he has worked some with his father who is in the same line of work. It was reported that the patient seems to have less confidence in himself and his abilities, as well as less of a tendency to "market" himself from a work standpoint. He was living in his home in Canton, TX at the time of the incident, but has been spending more time with his parent in Edgewood, TX since then.

**Review of Records:** Medical records reviewed included ER notes which described facial bruising, black eye, and nasal fracture. Drug toxicology screen dated 11/8/05 was negative. A CT of the brain performed on 11/7/05 showed a large left temporoparietal scalp hematoma along with mucosal thickening of the ethmoid air cells bilaterally. CT of his orbits on 11/7/05 reflected a nasal bone fracture, mucosal thickening of ethmoid and frontal sinuses, right greater than left, due to apparent trauma and bleeding, as well as chronic nasal septum deviation.

**Tests Administered:** Wechsler Adult Intelligence Scale (WAIS-3); Wechsler Memory Scale-3 (WMS-3); Halstead-Reitan Neuropsychological Test Battery; Wide Range Achievement Test-3 (WRAT-3); Lateral Dominance Exam; Grip Strength; Aphasia Screening Exam; Wisconsin Card Sorting Test (WCST); Stroop Neuropsychological Screening Test; Controlled Oral Word Association (COWA); Sensory Perceptual Exam; Trail Making Test A&B; California Verbal Learning Test (CVLT-2); Rey-O Complex Figure; IVA Continuous Performance Test; Clock Drawing; Grooved Pegboard; Rey-15 Item Test; Test of Memory Malingering (TOMM); Tower of Hanoi; Ruff 2&7; Neuropsychological Symptoms Checklist (NSC); Beck Depression Inventory-2 (BDI-2); Beck Anxiety Inventory (BAI); Post MTBI Symptom Checklist; Minnesota Multiphasic Personality Inventory (MMPI-2).

**Behavioral Observations:** The patient attended the testing session on time and casually dressed. Overall, he was cooperative and friendly with the testing situation and appeared to understand all directions. Mr. McBay appeared to give good effort on each test administered. His score on the Rey-15 Item Test and TOMM, two malingering inventories, were not suggestive of malingering. Overall, these tests are considered to be a valid estimate of his current abilities.

**Intellectual/Academic Abilities:** On the WAIS-3, he demonstrated a verbal IQ of 99 (average), a performance IQ of 90 (average), for a full scale IQ of 95 (average). The age corrected subtest scores are presented below:

<u>Verbal</u>		<u>Performance</u>	
Vocabulary	9	Picture Completion	9
Similarity	10	Digit-Symbol	9

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Arithmetic	11	Block Design	7
Digit Span	11	Matrix Reasoning	9
Information	11	Picture Arrangement	9
Comprehension	.8		

In terms of his verbal skills he demonstrated low average performance on a measure assessing social comprehension. Average performance was noted on measures assessing knowledge of vocabulary words, verbal concept formation, simple and complex auditory attention and general fund of knowledge. In terms of his performance skills he demonstrated low average skills on a measure assessing visual perceptual reasoning and problem solving. Average skills were noted on measures assessing attention to detail, visual motor learning and motor persistence, abstraction and problem solving and visual sequencing.

On the WRAT-3, he demonstrated the following grade equivalents: Reading-High School, Spelling-High School, and Arithmetic-8<sup>th</sup> grade. These are equivalent to the standard scores of 96 (39<sup>th</sup> percentile), 98 (45<sup>th</sup> percentile) and 93 (8<sup>th</sup> percentile), respectively. Some errors due to impulsivity were noted on the Arithmetic portion of the WRAT-3, and this may have contributed somewhat towards his math score. With the exception of perhaps a mild degree of decline involving arithmetic skills, his academic skills are generally commensurate with his level of education.

**Summary Scores:** On tests more sensitive to the biological integrity of the brain, the patient demonstrated a Halstead Impairment Index of 0.7 (70% of components test within the brain damage range). On the General Neuropsychological Deficit Scale, his score of 27 falls within the mildly impaired range.

**Attention/Concentration:** In terms of his auditory attention, he demonstrated average performance while attending to slowly paced material and mildly impaired skills while attending to more rapidly paced auditory information. He demonstrated mild to moderately simple visual attention and tracking skills. On a complex visual attention and tracking task requiring flexibility of thought and motor sequencing ability, he demonstrated low average performance. He demonstrated severely impaired skills on another visual attention task requiring rapid visual sequencing and processing and the ability to rapidly shift cognitive sets. Average skills were noted on another visual attention task that also required visual sequencing and ability to shift sets, as well as sustained vigilance.

On the IVA-Continuous Performance Test, a computer based measure assessing sustained auditory and visual attention / concentration, the patient demonstrated average performance in the auditory modality and mildly impaired skills in the visual modality.

**Abstraction/Problem-Solving:** On a computer based measure assessing problem solving and executive skills that patient demonstrated severely impaired performance. On other complex cognitive measures, he demonstrated average performance on a semi structured task requiring flexibility of thought, ability to shift cognitive sets and problem solving ability. However, he also demonstrated four "failure to maintain set" errors, suggesting disruption in sustained problem solving skills. On another measure assessing abstraction ability and logical analysis, he demonstrated mild to moderately impaired skills. On this test, he was required to "figure out" the underlying principle to use in a problem solving situation. Finally, on a complex psychomotor problem solving task (placing blocks in a form board while blindfolded), he demonstrated mildly impaired skills.

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**Language Skills:** On a brief aphasia screening exam he demonstrated evidence of dysnomia. He demonstrated average verbal fluency skills on a measure requiring him to generate as many words as possible beginning with a specific letter.

**Visual-Spatial Skills:** The patient demonstrated evidence of mild constructional dyspraxia upon examination. He performed adequately on a simple clock drawing task. Low average performance was noted on a WAIS-3 measure requiring visual spatial and visual motor integration skills. He demonstrated mildly impaired skills on a psychomotor problem solving task that has a strong spatial component.

**Memory:** In terms of his ability to incidentally learn information that he did not specifically set out to learn, he demonstrated mild to moderately impaired skills with simple information and low average skills with complex information.

In terms of his verbal memory, he demonstrated average immediate (SS=10) and 30 minute delayed recall (SS=9) for simple, paragraph length material. On a less structured list learning task, he demonstrated average memory storage as he was able to learn thirteen of sixteen words after five trials. He tended to benefit from verbal cuing and his recognition memory fell in the average range.

In terms of his visual memory, he demonstrated average immediate recall (SS=9), but mildly impaired 30 minute delayed recall (SS=5) for simple visual information. On a more complex visual memory measure, he demonstrated an adequate performance while reconstructing a complex geometrical design. However, his immediate and 30 minute delayed recalls fell within the severely impaired range. His recognition of specific details of the design was impaired, while his recognition of the overall gestalt of the design was within normal limits.

**Sensory-Motor Skills:** On simple motor measures assessing finger tapping speed, fine motor dexterity and grip strength, he demonstrated bilaterally adequate skills, however on the grip strength measure his left hand was weaker than expected when compared to his right hand. He did not demonstrate any simple sensory errors in the auditory or visual modalities, but demonstrated two right side tactile imperception errors. He did not demonstrate any finger agnosia errors, but demonstrated two right side finger tip number writing errors. His tactile form recognition performance was within normal limits. He did not demonstrate any visual field cuts upon gross visual field examination.

**Emotional Functioning:** Results of the MMPI-2 are considered to be generally valid. The patient's test taking approach is consistent with someone who is experiencing moderate levels of emotional distress which was communicated through his pattern of item endorsement. His profile indicates that Mr. McBay is experiencing moderate to severe levels of depression and anxiety. This level of depression could lead to reduced self esteem and self-confidence, as well as disruptions involving vegetative symptoms including sleep, energy, or appetite. His level of anxiety will likely give rise to excessive worry and rumination, possible panic attacks, as well as generalized feelings of anxiousness and tension. He is likely seen as somewhat suspicious and untrusting of others, and during times of increased stress his thinking may become more overtly paranoid in nature. As a result of his generalized anxiety and distrust, he is inclined to avoid contact with other people particularly in a social setting. Mr. McBay may be inclined to impulsively engage in behaviors without fully considering the consequences. He likely has a quick temper and may be seen as generally irritable and frustrated. There are also indications of increased somatic preoccupation which can be in response to physical injuries.



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Results of the BDI-2 reflect a severe level of depression. His score on the BAI reflects a moderate level of anxiety. On the NSC he endorsed items involving vision problems, Tinnitus, coordination and balance problems, numbness, tingling skin, pins and needles sensations, loss of feeling, headaches, memory problems, cognitive difficulty, depression, anxiety, anger, worry or guilt, loss of interest and change in attitudes. On the Post MTBI symptoms checklist the patient reported symptoms involving dizziness, loss of balance, poor coordination, headaches, nausea, vision problems, light sensitivity, numbness or tingling, poor concentration, forgetfulness, difficulty making decisions, slowed thinking, fatigue, difficulty falling asleep, anxiety or tension, depression or sadness, irritability and poor frustration tolerance. He also noted changes for the worse involving management of daily activities, health concerns, problems getting along with spouse, problems getting along with family members, participation in social and recreational activities and job performance.

Upon presentation, the patient's mood was depressed and anxious and his affect was restricted. Mr. McBay acknowledged that he has suffered from symptoms of depression and generalized anxiety since the accident. He stated that at first he tried to cope with these symptoms by excessively drinking alcohol, but now recognizes that alcohol does not make the memories and feelings of his incarceration any better. The patient admitted that he still tries to avoid thinking about what has happened to him, but has a difficult time doing so. He indicated that his inability to work to his prior potential is causing significant financial stress. His frustration with his inability to work is increased given the fact that he made approximately \$180,000 the year prior to the incident. He reported that he avoids "everything" including social functioning, friends and large groups. Mr. McBay acknowledged vegetative symptoms of depression including disruptions in sleep, energy and interests. His family added that the patient appears depressed, which is quite a change from his prior upbeat disposition.

**Summary:** Results of this neuropsychological evaluation reflects a mild degree of diffuse neuropsychological impairment along with several indications of specific right hemisphere dysfunction. General impairment was noted involving visual attention and tracking, mental flexibility (low average), cognitive shifting skills, visual problem solving and "executive" abilities, abstraction skills, as well as psychomotor problem solving. While the patient's simple problem solving skills appeared to be functionally intact, he demonstrated multiple "failure to maintain set" errors which demonstrated difficulties staying "on task" while performing problem-solving exercises. He also demonstrated average scores on another general cognitive task requiring visual processing and visual tracking skills. Right hemisphere impairment involved mild constructional dyspraxia. With regards to his visual memory skills, Brice demonstrated mildly impaired recall for simple information and moderately to severely impaired recall for complex visual information. Some degree of improvement in terms of visual recall occurred with cuing and prompting. Brice's performance IQ (PIQ = 90; right hemisphere) is falling at the low end of the average range. His scores reflect a mild degree of decline involving visual-spatial and visual-motor integration skills. Cognitive abilities associated with the left hemisphere were largely intact with the exception of indications of dysnomia (word finding) as well as subtle sensory dysfunction. His verbal (VIQ = 99; left hemisphere) is also falling in the average range and there are no indications of disruption involving verbally-based intellectual skills. His remaining verbal skills were intact and included most aspects of language, verbal recall for both contextual and non-contextual information, as well as right-sided simple motor skills. Mr. McBay's academic skills appear to be relatively intact for reading (high school) and spelling (high school), and perhaps a mild decline involving math skills (8<sup>th</sup> grade) are noted in part due to careless errors.

From an emotional / behavioral standpoint, this evaluation reflects that the patient is experiencing ongoing symptoms of post traumatic stress disorder (PTSD). That is, Mr. McBay continues to experience generalized anxiety and stress associated with the reported assault and is reporting

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disruptions involving disturbing memories, nightmares, as well as increased anxiety when ever he sees a law enforcement officer. Although he has attempted to repress these memories either through distraction or through alcohol, they continue to affect him on a regular basis. Besides the severe levels of depression and anxiety symptoms that are clinically evident, it appears that Brice's self-esteem and self-worth has also been negatively affected by this episode. He remains quite angry at the alleged perpetrators but also feels helpless in terms of being able to demand justice. As a result, his anger tends to be expressed towards family and friends that are closest to him. Contributing towards the expression of his anger are apparent organic personality symptoms which are resulting in increased feelings of irritability and frustration on a daily basis. Brice's level of trust in other people and in particular the legal system has substantially declined. Psychological testing reflected increasing levels of paranoia, anger, and social withdrawal. These symptoms, along with his panic attacks, are further contributing towards increased levels of social avoidance.

From a diagnostic standpoint, these results reflect indications of frontal lobe dysfunction consistent with residual effects from a concussion sustained in the reported assault. Primary brain regions affected by this concussion involve frontal and more specifically orbital-frontal regions of the brain. Primary cognitive areas which continue to be affected include elements of attention, processing speed, decision-making, as well as visual memory and recall. Of equal if not greater concern with these cognitive deficits involves the aforementioned mood and personality changes. These behavioral symptoms frequently accompany injuries involving orbital-frontal regions of the brain. The combination of cognitive, emotional/behavioral, and physical symptoms (e.g., headaches, lethargy) being reported are referred to as a post concussion syndrome (PCS). These concussion factors tend to dynamically interact with one another in such a way that improvements in one area (e.g., mood) may result in associated improvements in another area (e.g., cognition). The time frame that has elapsed since the injury (approximately 2 years) suggests that elements of this profile are likely permanent in nature.

**Diagnostic Impressions:** ICD-9

850.0	Concussion
310.1	Organic personality syndrome
310.2	Post concussion syndrome (PCS)
309.81	Post traumatic stress disorder (PTSD), chronic
296.22	Major depression, single episode, moderate

**Recommendations:** 1. Upon interview and feedback, Mr. McBay indicated his desire to avoid medication treatment if possible for the neuropsychiatric aspects of this PCS. Time was spent educating that in order to obtain optimal relief from his PTSD and PCS symptoms, some degree of medication management will likely be needed. Ideally, this patient would be referred to a local psychiatrist for appropriate medication management of his depression and anxiety-related symptoms. In the event that this option is not financially feasible, his family physician should consider a trial of Paxil or another SSRI which should help address some of these symptoms. Appropriate use of a benzodiazepine may also be indicated particularly given his panic attacks. Future consideration of a psycho-stimulant medication may help to address aspects of his inattention and processing issues, particularly given his prior diagnosis of ADHD as a child.

2. Follow-up outpatient neuropsychological counseling would help the patient to better understand the nature of his cognitive deficits as well as begin utilizing needed compensatory strategies. Further emphasis would be placed on mood stabilization, learning coping strategies to deal with his PTSD symptoms, as well as learning depression reduction strategies.

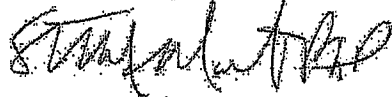
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3. Participating in outpatient cognitive remediation treatment would help to ensure that Mr. McBay is given every opportunity to improve the quality of his processing, decision-making, and other "executive" abilities that remain affected by this concussion. This would include the use of computer programs that target "higher level" cognitive abilities which typically are not adequately addressed with traditional outpatient cognitive therapy (e.g., speech therapy). I am aware of two programs in the Dallas, TX area that provides this type of rehabilitation including the office of Neuropsychologist Richard Fulbright, Ph.D. (972-250-1705).

4. Follow-up neuro-imaging studies such as a functional MRI (fMRI) would help to further document residual organic brain damage from this concussion.

5. Use of compensatory strategies such as a daily organizer / memory notebook would help the patient in terms of daily recall and organization. It may also be helpful for the patient to consider an electronic "palm pilot" since these have become more affordable and user friendly. Other strategies include a hand held tape recorder to record important meetings.

6. Referral to the Department of Assistive and Rehabilitative Services (DARS) would perhaps be helpful from a vocational standpoint. It is possible that DARS may be able to help provide resources to help with Mr. McBay's rehabilitation process. Thank you for this interesting referral.



Stephen K. Martin, Ph. D.  
Clinical Neuropsychologist